aetna Traditional Plan - SPOG

Coverage Period: 01/01/2013 - 12/31/2013
Coverage for: Individual + Family **Plan Type:** PPO
THE CITY OF SEATTLE

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-877-292-2480.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year In-network: Individual **$100** / Family **$300;** Out-of-network: Individual **$150** / Family **$450**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, In-network: Individual **$400** / Family **None**; Out-of-network: Individual **$1,600** / Family **None**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, copayments, short term rehabilitation expenses, neurodevelopmental therapy expenses balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.aetna.com or call 1-877-292-2480.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	——— None ———
	Specialist visit	20% coinsurance	40% coinsurance	——— None ———
	Other practitioner office visit	20% coinsurance	40% coinsurance	Coverage is limited to 10 visits per calendar year for Chiropractic and 12 visits for Acupuncture.
	Preventive care /screening /immunization	Not covered	Not covered, except 40% coinsurance for routine mammogram.	Not covered
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——— None ———

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families**	Generic drugs	$5 copay/ prescription (retail), $10 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs.
	Preferred brand drugs	$10 copay/ prescription (retail), $20 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$25 copay/ prescription (retail), $50 copay/ prescription (mail order)	Not covered	
	Specialty drugs	$5 copay(generic)/$10 copay(preferred)/$25 copay(non-preferred)	Not covered	———— None ————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	———— None ————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	———— None ————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance/40% coinsurance for non-emergency.	———— None ————
	Emergency medical transportation	20% coinsurance	20% coinsurance	Precertification required for Non-emergency care.
	Urgent care	$35 copay per visit	40% coinsurance	Covered both for urgent and non-urgent care.

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——— None ———
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification required for out-of-network care.
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	——— None ———
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	Precertification required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	——— None ———
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——— None ———

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Coverage is limited to 130 visits. Precertification required for out-of-network care.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 35 visits for Speech, Physical and Occupational Therapy combined.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 90 days per calendar year. Precertification required for out-of-network care.
	Durable medical equipment	20% coinsurance	20% coinsurance	———— None ————
	Hospice service	10% coinsurance	10% coinsurance	Precertification required for out-of-network care. Coverage is limited to $10,000 per lifetime or 6 months whichever is greater. Inpatient limited to 14 days per 6 month period and outpatient limited to 120 hours per 6 month period.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)		
• Bariatric surgery	• Habilitation services	• Preventive care
• Cosmetic surgery	• Hearing aids	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Routine eye care (Child)
• Dental care (Child)	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Glasses (Child)		• Weight loss programs
services.)		
• Acupuncture-limit of 12 visits per calendar year.	• Infertility treatment (Diagnosis & treatment of the underlying medical condition)	
• Chiropractic care-limit of 10 visits per calendar year	• Private-duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-292-2480. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-877-292-2480, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html

Language Access Services:

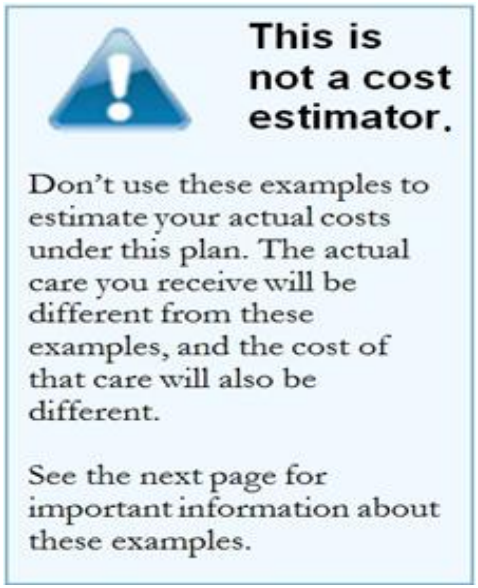
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-292-2480.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-292-2480.
如果需要中文的帮助，**请拨打这个号码** 1-877-292-2480.
Para obtener asistencia en Español, llame al 1-877-292-2480.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



Having a baby
(normal delivery)

- **Amount owed to providers:** $ 7,540
- **Plan pays:** $ 6,950
- **Patient pays:** $ 590

Sample care costs:

Hospital charges (mother)	$ 2,700
Routine obstetric care	$ 2,100
Hospital charges (baby)	$ 900
Anesthesia	$ 900
Laboratory tests	$ 500
Prescriptions	$ 200
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$ 7,540**

Patient pays:

Deductibles	$ 100
Copays	$ 0
Coinsurance	$ 300
Limits or exclusions	$ 190
Total	**$ 590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers** $ 5,400
- **Plan pays:** $ 4,780
- **Patient pays:** $ 620

Sample care costs:

Prescriptions	$ 2,900
Medical Equipment and Supplies	$ 1,300
Office Visits and Procedures	$ 700
Education	$ 300
Laboratory tests	$ 100
Vaccines, other preventive	$ 100
Total	**$ 5,400**

Patient pays:

Deductibles	$ 100
Copays	$ 70
Coinsurance	$ 230
Limits or exclusions	$ 220
Total	**$ 620**

Note: Your plan may have both **copays** and **coinsurance** for covered services; if so, these examples use **copays** only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.